STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUI			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIII	LDING	00	COMPL	ETED
		155446	B. WIN			06/05/	2012
			D. WII		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R			/ILKIE DR		
COVING	TON MANOR HEA	LTH AND REHABILITATION CEN	TER		WAYNE, IN 46804		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0000							
	This visit was for the investigation of		F00	000	This Plan of Correction is the center's		
	Complaint IN00	0108978.			credible allegation of compliance.	•	
	Complaint IN00108978-Substantiated.				Preparation and/or execution of this plan of correction does not constitute		
	_	ficiencies related to the			admission or agreement by the provide	der	
		ted at F309, F502, F505,			of the truth of the facts alleged or		
		ted at F309, F302, F303,			conclusions set forth in the statement deficiencies. The plan of correction is		
	and F514.				prepared and/or executed solely beca	ause	
	Survey dates: Ju	ine 1, 4, 5, 2012			it is required by the provisions of fede and state law.	eral	
	Facility number	: 000476					
	Provider numbe	er: 155446					
	Aim number: 1	00290870					
	1 11111 1101110 011	00230070					
	Survey team:						
	Ann Armey, RN	1					
	1,5						
	Census bed type	٠.					
	SNF/NF: 130						
	Total: 130						
	101.1.150						
	Census payor ty	rpe:					
	Medicare: 23	•					
	Medicaid: 72						
	Other: 35						
	Total: 130						
	Sample: 4						
	These deficience	ies reflect state findings					
		nce with 410 IAC 16.2.					
	cited in accorda	110 1AC 10.2.					

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

000476

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/18/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155446		ILDING	00	COMPI 06/05		
	PROVIDER OR SUPPLIE TON MANOR HEA	R LTH AND REHABILITATION CEN	STREET ADDRESS, CITY, STATE, ZIP CODE 5700 WILKIE DR FORT WAYNE, IN 46804					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL & LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE	
	REGULATORY OF	completed 6/6/12			CROSS-REFERENCED TO THE APPRODEFICIENCY)	PRIATE		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: E65N11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPL	ETED
		155446	B. WIN			06/05/	2012
			D. 1111		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				/ILKIE DR		
COVING	TON MANOR HEAL	TH AND REHABILITATION CEN	TER		WAYNE, IN 46804		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	, i	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0309 SS=D	483.25 PROVIDE CARE WELL BEING Each resident me must provide the services to attain practicable physically psychosocial we the comprehensicare. Based on observer record review, the an antibiotic after in a two day delay and the deficiency as with infections, we reviewed, in a safe findings include The clinical record reviewed on 6/4/indicated the resifacility on 3/4/11 include but were obstructive pulminations of DVT (Nursing notes, daindicated "residereddened, inflamed the residereddened, inflamed the residereddened the residered the resi	e/SERVICES FOR HIGHEST ust receive and the facility necessary care and nor maintain the highest ical, mental, and ill-being, in accordance with ive assessment and plan of ation, interviews, and he facility failed to obtain r it was ordered resulting by of treatment. Inffected 1 of 3 resident whose treatments were imple of 4. (Resident #E) : rd of Resident #E was 12 at 2:00 p.m., and ident was admitted to the hot limited to, chronic ionary disease and a Deep Vein Thrombosis). ated 5/21/12 at 2:00 p.m., ents (sic) left calf ied and warm to touch" ed the medical doctor id.	F03		1) Resident E completed the antibiotic therapy ordered with adverse effect. The facility became aware of this isolated deficient practice prior to the d of survey. The nurse responsi for the delayed transcription of the antibiotic order was educated by the Director of Staff Development regarding physicorders and the use of the Emergency Drug Kit (EDK). 2) The Unit Managers reviewed a resident's current Medication Administration Records for any deficient practice related to the delay of prescribed medication orders. Any further discrepent found, will follow through with notification of the physician for proper reporting of delay of treatment with new orders received, if indicated. Any nur responsible for a discreprancy receive disciplinary action. 3) In-servicing was provided by the Director of Staff Development the nursing staff reviewing "Pharmacy Services Guideline (Attachment A), "Emergency Development (Attachment A), "Emergency Developm	out ate fible fted cian all y e n cy se will ne to	DATE 06/22/2012
	*	, dated 5/21/12, indicated to receive Levaquin (an			Supply" (AttachmentB), and "Processing Physician Orders"	,	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIT	LDING	00	COMPLETED	
		155446	B. WIN			06/05/2012	
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	₹			ILKIE DR		
COVING	TON MANOR HEAI	LTH AND REHABILITATION CEN	TER		VAYNE, IN 46804		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	antibiotic used to	o treat infections) 250 mg			(Attachment C). A listing of		
	every day for fiv	re days due to "L (left)		medications available in the EDK was placed in each medication			
	shin warm & (an	nd) pink Hx (History) of			administration record. 4) Audi		
	DVT & cellulitis	s."			will occur daily by the unit	13	
					managers utilizing the "Daily		
	The May 2012 N	MAR (Medication			Medical Record Audit/DNS		
	I	Record) indicated the			Report"(Attachment D). Any		
		· · · · · · · · · · · · · · · · · · ·			adverse results from the audit		
	_	was noted on 5/22/12 and			result in disciplinary action for		
		stered on 5/23/12, two			offending nurse with education resources provided, if indicate		
	days after it was ordered.				Additionally, the results will be		
					discussed monthly during the		
	On 6/4/12 at 3:30	0 p.m., Resident #E's			QA&A meeting for a minimum	of	
	lower left leg wa	as observed with Unit			6 months. Audits must be 100)%	
	Manager #11. Tl	he left lower leg was not			accurate, thereafter, for three		
	_	ul. Both of Resident #E's			months for auditing to cease.5	· ·	
		discoloration of the skin			All education requirements for corrective action will be		
	_	Manager indicated was			completed by June 22, 2012		
	normal for the re	•			completed by duric 22, 2012		
		esident.					
	On 6/5/12 at 9:30	0 a.m. Unit Manager #11					
	indicated she tall	ked to the nurse who had					
	worked when the	e Levaquin order was					
		nit Manager indicated the					
		he order and it was not					
		the MAR until the next					
	day.	, the MATTIC than the heat					
	-	car indicated the Lavague					
	·	er indicated the Levaquin					
		the EDK (Emergency					
		ne nurse did not check the					
		sult, the medication was					
	not started until	two days after it was					
	ordered.						
	This Federal tag	relates to Complaint					

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PRINTED: 06/18/2012 FORM APPROVED OMB NO. 0938-0391

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155446	(X2) MULTIPLE CO A. BUILDING B. WING	00	COMP	E SURVEY LETED 5/2012		
	PROVIDER OR SUPPLIER TON MANOR HEALTH AND REHABILITATION CENT	STREET ADDRESS, CITY, STATE, ZIP CODE 5700 WILKIE DR FORT WAYNE, IN 46804					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	ILD BE	(X5) COMPLETION DATE		
	IN00108978. 3.1-37(a)						

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Event ID: E65N11

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Facility ID: 000476

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SU			SURVEY	
OF CORRECTION	IDENTIFICATION NUMBER:	A BUILDING 00			COMPLETED	
	155446				06/05/	2012
				ADDRESS, CITY, STATE, ZIP CODE		
PROVIDER OR SUPPLIER						
TON MANOR HEAL	TH AND REHABILITATION CEN	TER				
			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
`		PREFIX		CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
483.75(j)(1) PROVIDE/OBTA SVC-QUALITY/T The facility must services to meet The facility is res- timeliness of the Based on intervice the facility failed and hemo cult ste manner. This def residents whose in a sample of 4. (Resident #B and Findings include 1. The closed clir #B was reviewed and indicated the the facility on 3/ included but wer fracture and atria resident was adm 5/11/12, returned 5/15/12 and was hospital on 5/20/ The MDS (Minin assessment, date Resident #B had and was continer The MDS assess	AIN LABORATORY FIMELY provide or obtain laboratory the needs of its residents. sponsible for the quality and services. ews and record review, I to obtain a urinalysis cool tests in a timely ficiency affected 2 of 4 lab tests were reviewed I Resident #C) : mical record of Resident I on 6/1/12 at 1:30 p.m. e resident was admitted to 19/12, with diagnoses e not limited to, left arm all fibrillation. The mitted to the hospital on I to the facility on readmitted to the 12. mum Data Set) d 5/4/12, indicated no cognitive impairment at of bowel and bladder. ment indicated the	F05		1) A review of current standar was completed. Education wa provided by the Director of Standard Development to those involved with Resident B and Resident 2) During the implementation guidelines and guidance, all current lab orders were review by the unit managers. Records any deficient practice related to the delay of obtaining ordered labs will follow through with notification of the physician for proper reporting of delay of treatment with new orders received, if indicated. Any nur responsible for a discreprancy receive disciplinary action. 3) review of current "Lab Audit Operating Standard Guidelines was completed (Attachment E, was determined that the facility was utilizing the audit tool week instead utilizing the audit tool week instead utilizing the audit daily (Attachment F). Unit Manager will now be completing the audit daily. Additionally, guidance we given to the floor nurses to ensure all physician lab orders are completed timely and prevany delayed implementation of prescribed orders (Attachment). 4) The Daily Lab Audit will	s iff C. of ed s for o se will A s''. It white sent f G	DATE 06/22/2012
(PROVIDER OR SUPPLIER TON MANOR HEAL SUMMARY S' (EACH DEFICIEN REGULATORY OR 483.75(j)(1) PROVIDE/OBTA SVC-QUALITY/T The facility must services to meet The facility failed and hemo cult sto manner. This def residents whose in a sample of 4. (Resident #B and Findings include 1. The closed clir #B was reviewed and indicated the the facility on 3/ included but wer fracture and atria resident was adm 5/11/12, returned 5/15/12 and was hospital on 5/20/ The MDS (Minin assessment, date Resident #B had and was continer The MDS assess resident required	OF CORRECTION IDENTIFICATION NUMBER: 155446 PROVIDER OR SUPPLIER TON MANOR HEALTH AND REHABILITATION CEN' SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PROVIDER OR SUPPLIER TON MANOR HEALTH AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 483.75(j)(1) PROVIDE/OBTAIN LABORATORY SVC-QUALITY/TIMELY The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. Based on interviews and record review, the facility failed to obtain a urinalysis and hemo cult stool tests in a timely manner. This deficiency affected 2 of 4 residents whose lab tests were reviewed in a sample of 4. (Resident #B and Resident #C) Findings include: 1. The closed clinical record of Resident #B was reviewed on 6/1/12 at 1:30 p.m. and indicated the resident was admitted to the facility on 3/19/12, with diagnoses included but were not limited to, left arm fracture and atrial fibrillation. The resident was admitted to the hospital on 5/11/12, returned to the facility on 5/15/12 and was readmitted to the hospital on 5/20/12. The MDS (Minimum Data Set) assessment, dated 5/4/12, indicated Resident #B had no cognitive impairment and was continent of bowel and bladder. The MDS assessment indicated the resident required extensive assistance of	PROVIDER OR SUPPLIER TON MANOR HEALTH AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 483.75(j)(1) PROVIDE/OBTAIN LABORATORY SVC-QUALITY/TIMELY The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. Based on interviews and record review, the facility failed to obtain a urinalysis and hemo cult stool tests in a timely manner. This deficiency affected 2 of 4 residents whose lab tests were reviewed in a sample of 4. (Resident #B and Resident #C) Findings include: 1. The closed clinical record of Resident #B was reviewed on 6/1/12 at 1:30 p.m. and indicated the resident was admitted to the facility on 3/19/12, with diagnoses included but were not limited to, left arm fracture and atrial fibrillation. The resident was admitted to the hospital on 5/11/12, returned to the facility on 5/15/12 and was readmitted to the hospital on 5/20/12. The MDS (Minimum Data Set) assessment, dated 5/4/12, indicated Resident #B had no cognitive impairment and was continent of bowel and bladder. The MDS assessment indicated the resident required extensive assistance of	PROVIDER OR SUPPLIER TON MANOR HEALTH AND REHABILITATION CENTER SUMMARY STATEMENT OF DEPCIENCIES (EACH DEPTICENCE WINST BE PERCEDED BY PULL PREFIX TAG COMMECTION CENTER) SUMMARY STATEMENT OF DEPCIENCIES (EACH DEPTICENCE WINST BE PERCEDED BY PULL PREFIX TAG COMMECTION CENTER) 483.75(j)(1) PROVIDE/OBTAIN LABORATORY SVC-QUALITY/TIMELY The facility must provide or obtain laboratory services to meet the needs of its residents. The facility failed to obtain a urinallysis and hemo cult stool tests in a timely manner. This deficiency affected 2 of 4 residents whose lab tests were reviewed in a sample of 4. (Resident #B and Resident #C) Findings include: 1. The closed clinical record of Resident #B was reviewed on 6/1/12 at 1:30 p.m. and indicated the resident was admitted to the facility on 3/19/12, with diagnoses included but were not limited to, left arm fracture and atrial fibrillation. The resident was admitted to the hospital on 5/11/12, returned to the facility on 5/15/12 and was readmitted to the hospital on 5/11/12, returned to the facility on 5/15/12 and was readmitted to the hospital on 5/11/12, returned to the facility on 3/19/12, with diagnoses included but were not limited to, left arm fracture and atrial fibrillation. The resident was admitted to the hospital on 5/11/12, returned to the facility on 3/19/12, with diagnoses of the service of the provided by the Director of the physician for proper reporting of delay of treatment with new orders received, if indicated. Any nur responsible for a discreprancy was completed (Attachment E, was determined that the facility on solutionally, guidance we will now be completing the audit daily (Attachment E, Unit Manager and was continent of bowel and bladder. The MDS assessment indicated the resident required extensive assistance of the provider of the p	PROVIDER OR SUPPLIER TON MANOR HEALTH AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY PULL REGULATORY OR ISC IDENTIFYING INFORMATION) 483.75(j)(1) PROVIDE/OBTAIN LABORATORY SVC-QUALITY/TIMELY The facility must provide or obtain laboratory services to meet the needs of its residents. The facility failed to obtain a urinalysis and hemo cult stool tests in a timely manner. This deficiency affected 2 of 4 residents whose lab tests were reviewed in a sample of 4. (Resident #B and Resident #C) Findings include: 1. The closed clinical record of Resident #B was reviewed on 6/1/12 at 1:30 p.m. and indicated the resident was admitted to the facility on 3/19/12, with diagnoses included but were not limited to, left arm fracture and atrial fibrillation. The resident was admitted to the facility on 5/11/12, returned to the facility on 5/11

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i î		(X2) M	IULTIPLE CO	ONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155446	B. WIN	IG		06/05/	2012
NAME OF I	PROVIDER OR SUPPLIER	· ?	_	STREET A	ADDRESS, CITY, STATE, ZIP CODE	-	
			5700 WILKIE DR				
COVING	TON MANOR HEAI	LTH AND REHABILITATION CEI	NTER	FORT V	WAYNE, IN 46804		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG			DATE
					results from the audit will result disciplinary action for the	lt in	
	On 5/5/12 at 4:00 p.m., physician orders			offending nurse with educa			
	indicated resident #B was to have a				resources provided, if indicate		
	urinalysis with a	culture and sensitivity.			Additionally, the results will be		
					discussed monthly during the		
	There was no do	cumentation a urine			QA&A meeting for a minimum 6 months. Audits must be 100		
	specimen was ob	otained on 5/5/12.			accurate, thereafter, for three	J-70	
					months for auditing to cease.	5)	
	On 5/6/12 at 12:	00 p.m., nursing notes			All education requirements for	•	
	indicated the nur	rse attempted to obtain a			corrective action will be		
	urine specimen but the resident requested				completed by June 22, 2012.		
	the straight catheterization be done later.						
	On 5/6/12 at 4:0	0 p.m. (24 hours after it					
	had been ordered	• `					
		esident) UA (urinalysis)					
	obtained per stra	,					
	•	" The nursing notes					
	,	ent #B had experienced a					
	decline in her fu	•					
		netional level.					
	The urinolygic re	eport indicated the urine					
	<u> </u>	_					
	_	ceived by the laboratory					
	on 5/7/12 at 12:1	•					
	(20 hours after it	t was collected).					
	On 5/9/12 =4 2:20	0 m m					
		0 p.m., nursing notes					
		lus bacteria were present					
		urine. The nursing note					
		ture and sensitivity					
	results were still	pending.					
		me listed), physician					
	orders indicated	the resident was to					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION 00	(X3) DATE (COMPL		
THEFTERN	or condition	155446		LDING		06/05/	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	30,00	
NAME OF F	PROVIDER OR SUPPLIEF	t .			ILKIE DR		
COVING	TON MANOR HEAI	TH AND REHABILITATION CEN	NTER		VAYNE, IN 46804		
(X4) ID	·			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
		n antibiotic medication					
		ry tract infection) 250 mg					
	twice daily for fi	ve day.					
	On 5/9/12, four of	lays after the urinalysis					
	was ordered, the	final culture and					
	sensitivity report	indicated Resident #B's					
	urine cultured po	sitive for Enterococcus.					
	On 5/10/12, the	Cipro was discontinued					
	and Levaquin, 2:	50 mg every day, was					
	ordered.						
	_	tal Transfer Record					
		nt #B was transferred to					
	_	/11/12 at 6:30 p.m. with					
		ion, and decreased					
	urinary output.						
	The Hospital Dis	scharge Summary, dated					
	5/15/12, indicate	d Resident #B was					
	treated in the hos	spital for altered mental					
	status, and a urin	ary tract infection.					
	On 6/4/12 at 9:0	0 a.m., Unit Manager					
		d on Resident #B's unit					
		She indicated Resident					
		sistakenly been told that a					
	1	dered on 5/4/12 but it					
	1	ordered until 5/5/12. She					
	1	s not sure why the urine					
		ot obtained on 5/5/12 but					
	_	sident did refuse to have					
	· ·	eterization done because					
	uic suaigiii callie	delization done because					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		Ì	ULTIPLE CO LDING	NSTRUCTION 00	COM	TE SURVEY IPLETED		
		155446	B. WIN	IG		- 06/0	05/2012	
	PROVIDER OR SUPPLIEF	LTH AND REHABILITATION CE	NTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5700 WILKIE DR FORT WAYNE, IN 46804				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
	urine specimen with aboratory with specimen but to get the urine used Manager indicate the antibiotic on family requested and sensitivity records of the specimen but to get the urine used the antibiotic on family requested and sensitivity records of the specimen but the specimen but the specimen was interviewed no policy regard obtaining laboration was accepted practice.	10 indicated, after the was obtained on 5/6/12, as contacted to pick up they never actually came until 5/7/12. The Unit ed the physician ordered 5/8/12, because the lit, pending the culture						
	indicated she was on 4/16/12, with included but was replacement on 4 Admission order indicated the res Coumadin (a me blood clots) 4 mg	rs, dated 4/16/12, ident was to receive dication used to prevent g every day.						
	dated 4/17/12, in	d count laboratory report, adicated the resident had a of 8.2 (Normal Range						

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	AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155446		A. BUILDING B. WING			COMPLETED 06/05/2012	
	PROVIDER OR SUPPLIER TON MANOR HEALTH AND REHABILITATION CENT	•	STREET A	ADDRESS, CITY, STATE, ZIP CODE VILKIE DR WAYNE, IN 46804	•		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPE DEFICIENCY)		(X5) COMPLETION DATE	
	12-15.5) and a low hematocrit of 25.8 (Normal Range 35-48).						
	On 4/17/12, physician orders indicated the resident was to receive two units of packed red blood cells and was to have three hemo cult stool tests completed. There was no documentation the hemo cult stool tests were done. On 6/5/12 at 9:30 a.m., Unit Manager #10 indicated the hemo cult order was not noted properly and as a result, the tests were not done. This Federal tag relates to Complaint IN00108978. 3.1-49(a)						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPLI	ETED
		155446	B. WIN			06/05/	2012
				_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				/ILKIE DR		
COVING	TON MANOR HEAL	TH AND REHABILITATION CEN	TER		WAYNE, IN 46804		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0505 SS=D	RESULTS The facility must physician of the t	-					
	Based on interview	ews and record review,	F05	05	A review of current		06/22/2012
	the facility failed	to notify the physician			standards was completed.		
	when a laborator	y report was received.			Education was provided by the Director of Staff Development		
		affected 1 of 4 residents,			those involved with Resident E		
	•	ification of the physician,			During the implementation		
	in a sample of 4.	* *			of guidelines and guidance, all		
	in a sample of 4.	(Resident #B)			current lab orders were review		
	Findings include	:		by the unit managers. Records fo any deficient practice related to the delay of obtaining ordered			
	The closed clinic	al record of Resident #B			labs will follow through with		
		6/1/12 at 1:30 p.m. and			notification of the physician for	•	
		dent was admitted to the			proper reporting of delay of		
					treatment with new orders received, if indicated. Any nur		
		noses which included but			responsible for a discreprancy		
		to, left arm fracture and			receive disciplinary action.		
		Resident #B was			3) A review of current "Lab		
		ospital on 5/11/12,			Audit Operating Standard		
	returned to the fa	cility on 5/15/12 and was			Guidelines" was completed		
	readmitted to the	hospital on 5/20/12.			(Attachment E) . It was		
					determined that the facility was utilizing the audit tool weekly,	5	
	The MDS (Minir	num Data Set)			instead utilizing the audit daily		
	assessment, dated	d 5/4/12, indicated			(Attachment F). Unit Manager		
		no cognitive impairment			will now be completing the aud	dit	
		nt of bowel and bladder.			daily. Additionally, guidance w	as	
		ment indicated the			given to the floor nurses to		
					ensure all physician lab orders		
	•	extensive assistance of			are completed timely and prevany delayed implementation of		
	two for toileting.				prescribed orders (Attachment		
	On 5/5/12 at 4:00	p.m., physician orders). 4) The Daily Lab Audit will I	_{be}	
		t #B was to have a			forwarded to the Director of		
		culture and sensitivity.			Nursing for review. Any adver	se	

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i '		(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPL	
		155446	B. WIN	IG		06/05/	2012
N. 1	PROTUBER OF STREET			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	<u>:</u>		5700 W	ILKIE DR		
COVING	TON MANOR HEAL	TH AND REHABILITATION CEN	NTER	FORT V	WAYNE, IN 46804		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	Γ		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	DATE
TAG	On 5/6/12 at 4:00 indicated a urined were faxed to the 10:08 p.m. There was no do physician was no urinalysis results the facility. On 5/8/12 at 3:30 indicated three p Resident #B's urindicated the cult results were still. On 5/8/12 (no time order indicated Freceive Cipro (art for the urinary treatment twice daily for firm the May 2012 M. Administration F. Resident #B receive Cipro on 5/8/12 at 3:30 indicated F. The May 2012 M. Administration F. Resident #B receive Cipro on 5/8/12 at 3:30 indicated F. The May 2012 M. Administration F. The May 2012 M. Administration F. Resident #B receive Cipro on 5/8/12 at 3:30 indicated F. The May 2012 M. Administration F. Resident #B receive Cipro on 5/8/12 at 3:30 indicated F. The May 2012 M. Administration F. Resident #B receive Cipro on 5/8/12 at 3:30 indicated F. The May 2012 M. Administration F. Resident #B receive Cipro on 5/8/12 at 3:30 indicated F. The May 2012 M. Administration F. Resident #B receive Cipro on 5/8/12 at 3:30 indicated F. The May 2012 M. Administration F. Resident #B receive Cipro on 5/8/12 at 3:30 indicated F. The May 2012 M. Administration F. Resident #B receive Cipro on 5/8/12 at 3:30 indicated F. The May 2012 M. Administration F. The May 2012 M. Administration F. Resident #B receive Cipro on 5/8/12 at 3:30 indicated F. The May 2012 M. Administration F. The May 2012 M. Administrat	O p.m. nursing notes e specimen was obtained. Inted the urinalysis results e facility on 5/7/12 at cumentation the otified about the after they were faxed to on an antibiotic medication), act infection, 250 mg we day. In p.m. nursing notes lus bacteria were noted in the ine. The nursing note ture and sensitivity pending. In physician's Resident #B was to an antibiotic medication), act infection, 250 mg we day. In the physician's Record) indicated eived the first dose of		TAG	results from the audit will results from the audit will results ciplinary action for the offending nurse with education resources provided, if indicate Additionally, the results will be discussed monthly during the QA&A meeting for a minimum 6 months. Audits must be 10 accurate, thereafter, for three months for auditing to cease. 5) All education requirement for corrective action will be completed by June 22, 2012.	nal ed. e	DATE
	OH 0/ 1/12 at 7.00	o a.m., Omit manager nio	ı				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/18/2012 FORM APPROVED OMB NO. 0938-0391

I 155446		A. BU	2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY BUILDING WING (COMPLETED 06/05/2012)					
NAME OF PROVIDER OR SUPPLIER COVINGTON MANOR HEALTH AND REHABILITATION CENTE			STREET ADDRESS, CITY, STATE, ZIP CODE 5700 WILKIE DR					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE		
TAG	indicated the physician should have been notified when the urinalysis report was faxed to the facility but there was no documentation the physician was notified until the following evening. On 6/5/12 at 10:15 a.m., Unit Manager #11 indicated there was no specific policy regarding the notification of the physician about laboratory results but it was expected that the nurses would notify the physician when pertinent laboratory test results were received. This Federal tag relates to Complaint IN00108978. 3.1-49(f)(2)		TAG	DEFICIENCY		DATE		

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A BUILDING B. WING NAME OF PROVIDER OR SUPPLIER COVINGTON MANOR HEALTH AND REHABILITATION CENTER (X4) ID PROVIDER'S RECHARD OF DEFICIENCY MUST BE PERCEDED BY FULL RECORD OR LSC IDENTIFYING INFORMATION) FOST 483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.
NAME OF PROVIDER OR SUPPLIER COVINGTON MANOR HEALTH AND REHABILITATION CENTER (X4) ID PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F0514 483.75(I)(1) RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the
NAME OF PROVIDER OR SUPPLIER COVINGTON MANOR HEALTH AND REHABILITATION CENTER (X4) ID PREFIX TAG FORT WAYNE, IN 46804 STREET ADDRESS, CITY, STATE, ZIP CODE 5700 WILKIE DR FORT WAYNE, IN 46804 ID PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) FO514 SS=D RES RECORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the
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TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG PERCORDS-COMPLETE/ACCURATE/ACCE SSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the
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of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the
care and services provided; the results of any preadmission screening conducted by the
preadmission screening conducted by the
State; and progress notes.
, , , , , , , , , , , , , , , , , , ,
Based on interviews and record review, F0514 1) A review of the current 06/22/2012
the facility failed to document a skin
assessment and documented a treatment Opereating Standard Guidelines" (Attachment H), and the "Skin
that was not done. This deficiency Intergrity Standard" (Atatchment
affected 1 of 4 residents, whose records // was completion. Upon review, it
were reviewed, in a sample of 4. was determined that re-education
(Resident #B) was required of all nursing staff
rather than revision of the standards. Education was
Findings include: provided to those involved with Resident B by the Director of staff
1. The closed clinical record of Resident Development. Skin assessments were
#B was reviewed on 6/1/12 at 1:30 p.m. conducted on all residents as
and indicated the resident was admitted to delegated by the unit managers.
the facility on 3/19/12, with diagnoses No further deficiencies were
included but were not limited to, left arm found. Treatment records were reviewed.
fracture and atrial fibrillation. The reviewed. 3) In-servicing was provided
resident was admitted to the hospital on for all nursing staff by the Director
5/11/12, returned to the facility on of Staff Development reviewing
5/15/12 and was readmitted to the
skin integrity.
hospital on 5/20/12. 4) The unit managers will utilize the "Treatment

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STATEMENT OF DEFICIENCIES X		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A BIII	LDING	00	COMPL	ETED
		155446	B. WIN			06/05/	2012
			D. WII		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER	t			ILKIE DR		
COVINGTON MANOR HEALTH AND REHABILITATION CENTER							
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)		DATE
	The May 2012 MAR (Medication				Documentation/Weekly Audit"		
	Administration I	Record) indicated		(Attachment J) to ensure			
	Resident #B was	receiving Coumadin.			completeness of documentation for skin issues and treatments		
	The May 2012 T	· ·			The Director of Nursing will		
	1	Record) indicated the			review the audits for any adve	rse	
		ave knee high Ted hose			results. Any deviation from the		
		•			policy will result in immediate		
	on in the morning and off at bedtime.				disciplinary action and/or additional education. Additional	ally,	
	A late entry nurs	ing notes, for 5/11/12 at			the results will be discussed	-	
	_	ted the resident had a			monthly during the QA&A		
	pink area to her left shin measuring 10 cm by 6 cm.				meeting for a minimum of 6		
					months. Audits must be 100% accurate, thereafter, for three)	
					months for auditing to cease.		
	There was no do	cumentation the area was			5) All education requirement	nts	
					for corrective action will be		
	assessed after 6:15 a.m. on 5/11/12.				completed by June 22, 2012.		
	_	tal Transfer Record					
	indicated Reside	nt #B was transferred to					
	the hospital on 5	/11/12 at 6:30 p.m.					
	The hospital eme	ergency room report,					
	_	idicated the resident had					
	· ·						
	bruising to the lateral aspect of the left calf and a left lower leg hematoma. There						
		· ·					
		tation the bruise or					
	hematoma were measured or that pictures were taken of the areas in the emergency room. A hospital laboratory report, dated						
	5/12/12 indicated the resident had an						
	elevated PT (prothrombin time) of 87.1						
	`*	0.4-12.5) and had an					
	l `	ternational Normalized					
	`	ormal range 23).					
	Natio) 01 8.3 (110	minai tange 43).					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE S			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155446		A. BUI	A. BUILDING 00 COMPLETED 06/05/2012						
		155440	B. WIN			06/05/	2012		
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE				
COVINGTON MANOR HEALTH AND REHABILITATION CENT			NTER	5700 WILKIE DR TER FORT WAYNE, IN 46804					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)		
PREFIX TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE		
TAG	On 6/4/12 at 9:50 a.m., CNA #12, who			TAG	DEI TOLERO I I		DATE		
	worked on Resident B's unit on the day shift on 5/11/12, was interviewed. The								
	_ ·	on 5/11/12, when she							
		Resident #B's Ted hose,							
	_	plained her left leg hurt.							
		ted the back of Resident							
		ittle red" so she got the							
	_	the night nurse checked							
	her leg. The CNA	A indicated she applied							
	the Ted hose after the nurse checked Resident #B's leg.								
	On 6/4/12 at 204	p.m., RN #13, who was							
	the day nurse on Resident #B's unit on								
	5/11/12, was interviewed. She indicated								
	_ ~	old her Resident #B had a							
		the back of her left leg.							
		d she rolled the Ted hose							
	down and checked the resident's left leg								
		afternoon of 5/11/12.							
	RN #13 indicated she noted no bruising								
		t did observe a pink/red							
		of the resident's calf. RN							
	#13 further indic	sessment of Resident #B's							
	left lower leg.	SESSITICITE OF RESIDENT #B S							
	ich lower leg.								
	2. Resident #B r	returned to the facility							
	from the hospital	-							
	mospitu								
	A non pressure s	kin condition report,							
	_	idicated the resident had a							

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				NSTRUCTION 00	(X3) DATE COMPL				
		155446		BUILDING			06/05/2012		
			b. WIIV		ADDRESS, CITY, STATE, ZIP CODE				
NAME OF PROVIDER OR SUPPLIER				5700 WILKIE DR					
COVINGTON MANOR HEALTH AND REHABILITATION CEN			NTER	TER FORT WAYNE, IN 46804					
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE			(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION		
TAG		·	+	TAG	DET CHAVETY		DATE		
	13.8 cm by 11.9 cm dark red purple bruise on her left lateral calf.								
	on her left lateral can.								
	On 5/16/12 and order was obtained to apply Kerlix to the left lateral calf.								
	TI 16 2012 T	ND: 1' + 14 TZ 1'							
	1	AR indicated the Kerlix be applied every shift.							
	_	documented as being							
		•							
	applied on every shift, including on 5/19/12, during the evening shift and on 5/20/12 during the night an day shifts.								
	5/20/12 daring the hight air day shirts.								
	On 5/19/12 at 10	0:15 p.m., nursing notes							
	indicated "discol	loration and fluid filled							
	blister cont. (con	ntinues) to LLE (left							
	• • • • • • • • • • • • • • • • • • • •	. Kerlix in place as							
	ordered"								
	There was no fu	rther documentation							
		wer left calf until							
		p.m., (14 hours later)							
		ar measuring 4.5 cm by 3							
	cm and a blood f	filled blister measuring 1							
	cm by 2cm were noted on the left calf.								
	05/20/122	15 mm - 41 m A m 4							
		15 p.m., the Acute							
	_	er Record indicated asferred to the hospital							
	per family reque	•							
	per ranning reque	St.							
	On 6/4/12 at 2:1	5 p.m., LPN #14, who							
	documented she	changed the Kerlix							
dressing on the both the evening and night									

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE (COMPL				
155446			LDING	00	06/05/				
1.55.1.5		B. WIN		PRESIDENCE CONTROL OF CORP.	00/00/	2012			
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE				
COVINGTON MANOR HEALTH AND REHABILITATION CEN			ITFR	5700 WILKIE DR TER FORT WAYNE, IN 46804					
			11-11	<u> </u>	77 (TVL), IIV 1000 I		(715)		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION		
TAG				TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	DATE		
		through 5/20/12, was							
		rding the condition of							
	_	wer left leg during the							
	dressing changes								
	1	ed she worked a 12 hour							
		o.m. through 6:00 a.m. on							
	_	#14 indicated she							
		x one time during the 12							
		was uncertain of the time							
		hange but indicated and							
	I -	her assessment of the							
		the nursing notes when							
	she changed the	_							
		ed she initialed on the							
		I the treatment two times							
		and night shift) but she							
	_	the treatment one time							
	during her twelv								
		umented that the Kerlix							
	•	anged on the night shift							
		was not changed.							
	when it actually	was not changed.							
	On 6/5/12 at 0.21	0 a.m., Unit Manager #11							
		•							
	was interviewed and indicated treatments should not be initialed if they are not								
	done.	tialed if they are not							
	done.								
	This Endows! to =	ralates to Complaint							
	Inis Federal tag IN00108978.	relates to Complaint							
	11NUU1U89/8.								
	2.1.50(a)(1)								
	3.1-50(a)(1)								
	3.1-50(a)(2)								

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Event ID: E65N11

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/18/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155446		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 06/05/2012				ETED		
NAME OF PROVIDER OR SUPPLIER COVINGTON MANOR HEALTH AND REHABILITATION CENT			STREET ADDRESS, CITY, STATE, ZIP CODE 5700 WILKIE DR					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: E65N11

Facility ID: 000476

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